CONSENT FOR TREATMENT

New Outlook Counseling Center

Please initial each and sign below

_____ **Treatment Choice/Involvement**

I understand I have made a choice to be involved in treatment. I understand therapy is a cooperative effort between me and my therapist and I agree to keep him/her aware of my needs, resolving any difficulties which may arise. Risks and/or benefits of treatment will be discussed during my first session. At time of termination of therapy we will mutually discuss the best way to end the therapeutic relationship however; I may choose to terminate therapy at any time.

_____ **Release of Medical Information/Insurance Authorization**

I authorize New Outlook Counseling Center, Inc to release necessary medical information to appropriate third parties for reimbursement purposes and/or to person authorized to conduct service utilization reviews. I understand that a photocopy of this authorization is as authentic as the original signed authorization.

_____ **Failure to Provide Information**

If I fail to release information or provide information requested by an available payer source, I will be responsible for payment on all services at full fee.

_____ **Confidentiality**

I understand my treatment will be kept in strictest confidence. Release of information will only occur through my informed, signed, and witnessed consent. The only exceptions to this are those required/allowed by law, including perpetration of sexual abuse, dangerousness to self or others, and treatment of minors. Note: we do consult regularly with other professionals regarding our clients in order to provide you with the best possible service. Names or other identifying information are never mentioned; client identity remains completely anonymous and your confidentiality will be fully maintained. Sessions are not recorded unless specific consent is given.

_____ **Responsibility for Charges**

I understand that payment is due at the time of services and other arrangements must be approved in advance. I agree that I am responsible for any allowable charges for services rendered as well as charges not paid by my insurance. Nonclinical services are not covered by insurance these include preparation of documents, nonemergency phone calls, etc. will be billed at the rate of $200 per hour, $100 per half hour. I will be financially responsible to pay for any costs incurred to collect this debt, including but not limited to collection fees, interest fees, and attorney fees.

_____ **Court Appearance**

We **do not** provide forensic services for the purposes of providing expert witness testimony for court proceedings. If we are subpoenaed to court by your attorney, the fees for clearing schedules, reviewing records, travel and appearance is $1,500. This must be received 7 working days prior to court appearance. If the court is continued you will be responsible for the same fees prior to the next hearing. If hearing is cancelled with 48 hour notice, you will be reimbursed $750. There will be no reimbursement if hearing is cancelled with less than 24 hour notice.

_____ **Notice of Cancellation**

I understand that making an appointment is a contract between New Outlook Counseling Center, Inc and myself. The appointment time is reserved for my convenience and to provide me with adequate time to discuss issues. I understand that New Outlook Counseling Center Inc. offers reminder notifications as a courtesy however it does not guarantee that reminder notifications will be made. I also understand that failure to receive reminder notification for any reason does not release me from my obligation to keep my appointment. **Cancellations require 24 hour business day notice. I understand there is a $45 late cancellation fee and a no show fee of $75 for therapy appointments. For medication services the late cancel/no show is for the cost of visit. Payment will be required before any additional appointments are scheduled. A second "no show" occurrence or several late cancel may result in forfeiture of future appointments.** Due to Medicaid policy, these fees will not apply to Medicaid clients however according to Medicaid policy the therapist does reserve the right to cancel all future appointments

_____ **I have been given a copy of New Outlook Counseling Center, Inc Notice of Privacy Practices.**

I, undersigned, or parent/legal guardian for above named minor, agree and consent to participate in mental health services offered and provided by New Outlook Counseling Center, Inc. I understand I am consenting and agreeing only to those mental health services that the above provider is qualified to provide within the scope of the provider's license, certification, and training.

I hereby certify that I have been informed of and understand the above statements. I also certify that I have read and understand the office polices and agreement for services.

Client	Date	Parent/Legal Guardian	Date
Witness	Date	Parent/Legal Guardian	Date